

Health Care Reform: Lessons From Canada

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Although Canadian health care seems to be perennially in crisis, access, quality, and satisfaction in Canada are relatively high, and spending is relatively well controlled. The Canadian model is built on a recognition of the limits of markets in distributing medically necessary care.

Current issues in financing and delivering health care in Canada deserve attention. Key dilemmas include intergovernmental disputes between the federal and provincial levels of government and determining how to organize care, what to pay for (comprehensiveness), and what incentive structures to put in place for payment.

Lessons for the United States include the importance of universal coverage, the advantages of a single payer, and the fact that systems can be organized on a subnational basis. (*Am J Public Health*. 2003;93:20–24)

TO AMERICANS, CANADA

resembles the girl next door—familiar but often taken for granted. Despite flurries of interest in the Canadian health care system whenever the United States contemplates implementing universal health insurance, misunderstandings about its nature abound. Indeed, there is no Canadian system; instead, there are a set of publicly financed, provincially run insurance plans covering all legal residents for specified service categories, primarily “medically necessary” physician and hospital care. Neither does Canada have socialized medicine; these services are delivered by private providers. In all industrialized nations, health care seems to be perennially in crisis; however, access and quality in Canada are relatively high, spending relatively well controlled, and satisfaction high, although declining. Canadians remain devoted to their system, but they are increasingly worried that it may not survive.

Recently, several provincial commissions investigated health care and weighed in with their recommendations,^{1–3} while the Kirby Senate Committee⁴ and the national Romanow Royal Commission⁵ are completing extensive research and consultation activities and readying their final reports. What will emerge is unclear, but Canadians have loudly indicated their hopes and fears for the future. Although the Canadian model per se is unlikely to be adopted in the United States, it can provide clear lessons for its neighbor—both positive and negative.

HEALTH SYSTEMS AND THE LIMITS TO MARKETS

Most markets distribute goods on the basis of supply and demand, with price signals used to affect production and consumption decisions. When price drops, demand should increase, with a near-infinite demand for free goods. Conversely, with fixed supply and high demand, price should rise until enough people get priced out of the market to balance supply against this new (lower) level of demand at the new equilibrium price. Yet health care markets stubbornly refuse to follow these economic laws. Economists have debated why this is so and whether they can force health care to behave in accordance with theory. If the discrepancies result only from “asymmetry of information” (because the person who provides services also determines which services must be purchased), providing better information can produce better-informed consumers and allow market forces to prevail. Yet most health economists, particularly outside the United States, recognize that the key problem instead rests with “need.” Consider the following scenarios⁶:

1. You want a taxi to take you to a destination across the city but have no money. Should you be taken there anyhow?
2. You win an all-expenses-paid week for two to a destination of your choice, which must be taken within the next 12 months. Do you accept?

3. You enter a hospital emergency room with a ruptured appendix but no money. Should you be treated anyhow?
4. You win free open-heart surgery in the hospital of your choice, which must be performed within the next 12 months. Do you accept?

Although the first 2 scenarios fit the predictions of economic models, the next two do not. Most people agree that the taxi driver need not take you, thus pricing you out of the taxicab market. Yet most also agree that the hospital must treat your appendix, and they would be horrified were you turned away for financial reasons. In economic terms, however, this means that you cannot be priced out of the market for appendix care; attempting to incorporate market forces means that we have set up an economic model in which there is a “floor price” (whatever charity or government will pay) but no ceiling price, because anyone priced out falls back into the publicly funded tier.

Although this model is attractive for providers, who are ensured that they will get at least the floor price, with any additional private charges as a bonus, 2 disquieting consequences follow. First, market forces are less able to achieve cost control. Second, deterioration of publicly funded services is likely because there would be no reason for consumers to pay extra for care unless the publicly funded tier is inadequate (or perceived to be inadequate). Accordingly, Canadian health policy analysts have

vehemently defended the principle of “single-tier” publicly funded medicine for “medically necessary” services, not only on the usual grounds of equity but on the grounds of economic efficiency. Multiple payers are seen not only as diminishing equity but also as increasing the burden on business and the economy to pay those extra costs.

Similarly, although most people would be eager to take free trips, few wish open-heart surgery unless they need it. Canadian health policy has rejected the language of consumer sovereignty in favor of the language of need. However, balancing consumerism against need is an ongoing tension. Most recent reform documents—in Canada and abroad—pay deference to both the language of patient rights and the language of evidence-based medicine, with little attention to how these potentially conflicting concepts are to be reconciled.

All health systems must perform similar functions. Mechanisms must be in place to determine how care will be *financed*. Policymakers must determine which costs will remain the responsibility of individuals and which will be *socialized* across many potential recipients. This risk spreading can occur on a voluntary basis or can be mandatory. However, the distribution of risks is not uniform—a very small number of individuals will account for a very large proportion of health expenditures.⁷ Accordingly, almost all nations except the United States have recognized that voluntary risk pooling within a competitive market for financing is unlikely to work, precisely because insurers need only avoid a small number of potential clients to

avoid a large proportion of health expenditures, often making high risks uninsurable. Canada retains a widespread consensus that a single payer should be retained for core services; the debates are over what counts as core services and how much financing is required.

Systems also vary according to how care is organized and *delivered*. What is the role of the hospital? How will different sectors be coordinated? How much authority rests with physicians?

Finally, systems must pay attention to how resources will flow from those paying for care to those delivering it. This dimension, which we have termed *allocation*, incorporates the incentives guiding the behavior of providers and care recipients.

FEDERALISM AND HEALTH CARE

Because Canada’s 1867 constitution assigned most health care responsibilities to provincial jurisdiction,⁸ Canadian health policy is inextricably intertwined with federal–provincial relationships. Canada is a federation of 10 provinces plus 3 sparsely populated northern territories. These provinces vary enormously in both size and fiscal capacity, ranging from the Atlantic province of Prince Edward Island, with a 2001 population of 135 000, to the industrial heartland of Ontario, with 11.4 million. The history of the often contentious evolution of the system (and the reactions by physicians) has been told elsewhere.^{9–12} From the outset, it represented an attempt to balance the desire of Canadians for national standards of service against the differing fiscal capacities of the various provinces and

provincial insistence that their jurisdiction be respected.

Financing the Canadian health care system accordingly evolved incrementally within individual provinces, as they responded to market failure, with national government involvement through a series of programs to share costs with the provinces. Initially, Ottawa provided funding for particular programs, such as public health, hospital construction, and training health personnel. In 1957, the Hospital Insurance and Diagnostic Services Act (HIDS)¹³ was passed with all-party approval; it paid approximately half the cost of provincial insurance plans for hospital-based care, as long as the plans complied with specified national conditions. The 1966 Medical Care Act¹⁴ cost-shared provincial insurance plans for physician services under similar provisions. By 1971, all provinces had complying plans insuring their populations for hospital and physician services. Because provinces have jurisdiction, one size does not fit all; there are considerable variations within Canada. In addition, although the financing arrangements were changed in 1977 to a mixture of cash and tax points (reducing the federal tax rates to allow the provinces to take up the resulting “tax room”), the same national terms and conditions initially introduced in HIDS were reinforced in the 1984 Canada Health Act.¹⁵ The system accordingly reflects a hospital/doctor-centered view of health care as practiced in 1957, which is becoming increasingly inadequate.

In order to receive federal money, the provincial insurance plans had only to comply with the following national terms and conditions:

1. Public administration. This frequently misunderstood condition does not mandate public delivery of health services; most care is privately delivered. It represents a reaction to the high overheads associated with private insurance when the system was introduced,¹⁶ and it requires that the health care insurance plan of a province “be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province”¹⁵ and its activities subject to audit. This administration can be delegated, as long as accountability arrangements are in place.
2. Comprehensiveness. Coverage must include “all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.”¹⁵ (Insured dental services are defined as those that must be performed within hospitals; practically, less than 1% of dental services so qualify.)
3. Universality. The plan must entitle “one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.”¹⁵
4. Portability. Provisions must be in place to cover insured people when they move between provinces, and to ensure orderly (and uniform) provisions as to when coverage is deemed to have switched. The details are worked out by interprovincial agreements. Although there are some irritants, in general, out-of-province care incurred during short visits (less than 3 months) remains the responsibility of the home province, which can set limitations (e.g., refuse to cover

elective procedures). Out-of-country care is reimbursed at the rates payable in the home province.

Since these rates are considerably less than what would be charged in the United States, Canadians leaving the country are strongly advised to have supplementary travel health insurance.

5. Accessibility. Provincial plans must “provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons.”¹⁵ Other provisions require that hospitals and health providers (usually physicians) receive “reasonable compensation,” although the mechanisms are not defined.

In practice, this balancing act means that the federal government cannot act as decision-maker, although it may occasionally attempt to influence policy directions through providing money or attempting to suggest guidelines. However, the comprehensiveness definition gives Ottawa a major influence on what services must be insured by provincial governments. The Canadian Institute for Health Information estimates that approximately 99% of expenditures for physician services, and 90% of expenditures for hospital care, come from public sector sources. Insurance coverage for such services is not tied to employment. However, other sectors (especially pharmaceuticals, chronic care, and dental care) are much more heavily funded from the private sector, including reliance on employment-based benefits.¹⁷ Overall, about 70% of Canadian health expenditures comes from

public sources, putting it among the *least* publicly financed of industrialized countries.¹⁸

For decades, delivery was largely unaffected by public financing. Most hospitals were private, not-for-profit organizations with independent boards. Recently, all provinces except Ontario subsumed hospitals into independent (or quasi-independent) regional health authorities, which were given responsibility for delivering an assortment of services.^{19,20} (Ontario retains private not-for-profit hospitals, although the provincial government has become increasingly obtrusive, especially for those hospitals running deficits.) Physicians are private small businessmen, largely working fee-for-service, and moving only slowly (and voluntarily) from solo practice into various forms of groups. In some provinces, provincial governments have been attempting to encourage the move toward rostered group practice paid on a capitated basis, with remarkably little success to date.²¹ Individual patients have free choice of physicians. Bills are usually submitted directly to the single payer, which means a decided lack of paperwork for either patient or provider. Indeed, in 1991, the US General Accounting Office estimated that, if the United States could get its administrative costs to the Canadian level, it could afford to cover the entire uninsured population.²²

ISSUES ARISING

Financing the System

In the mid-1980s, Canada faced a deficit trap. To avoid it, they squeezed supply. The federal government unilaterally changed the formula for transfers to the provincial governments,

which led to a significant reduction in the cash portion of the transfer. In turn, provincial governments chopped budgets to hospitals, which in turn led to considerable growth in day surgery, reduction in hospital bed numbers, and instability in the nursing employment market.²³ They also attempted to squeeze physician fees. The result was that provincial expenditures per capita for health care, inflation adjusted, were lower in 1997 than they had been in 1989.⁶ The search for efficiency proceeded apace, to the point where most hospitals were running at 95% occupancy or greater, and most providers felt that they were overworked and underpaid.²⁴

Under the rubric of “sustainability,” the pent-up demand for restoring funding (and incomes) to previous levels has dominated recent health policy discussions. Advocates of privatization claim that this increased spending cannot be met from public sources, while health reformers argue that if the issue is the ability to meet total costs (rather than the more political question of who will bear them), a single payer should be retained. Some business leaders, recognizing that the search for alternative sources of revenue may represent a greater burden on payroll, support a single payer. Others retain an ideological objection to government involvement. Providers voice support in theory for public payment, but only if it guarantees that they will receive the resources they require to provide the level of services they feel is necessary. The public agrees; they are highly supportive of a single payer, but not if this means they would be denied

care. Although it is not clear the extent to which waiting lists are an actual problem (this varying considerably by procedure and geographic area), they remain a highly potent and symbolic issue.

Another key dilemma is comprehensiveness, spoken of in terms of “defining the basket of services.” Although provinces are free to go beyond the federal conditions—which establish a floor rather than a ceiling—in practice, many prefer to cut taxes. As care shifts from hospitals, it can shift beyond the boundaries of public insurance. Patients being treated in a hospital have full coverage for such necessities as pharmaceuticals, physiotherapy, and nursing. Once they are discharged, these costs need no longer be paid for from public funds.²⁵ Some provinces still pay for such care; others do not. The ongoing debate as to what should be “in” or “out” of the publicly financed services, and the role (if any) for user charges, has focused largely but not exclusively on “pharmacare” (coverage for outpatient prescription drugs) and home care.

The “first law of cost containment” states that the easiest way to control costs is to shift them to someone else. These issues have flowed over to massive disputes between levels of government (particularly the federal and provincial governments) and between provincial governments and providers, including some work stoppages by physicians and nurses in certain provinces. These disputes in turn are often resolved by sizeable reimbursement increases, which in turn increases pressure on other provinces to match the enriched contracts.

Delivery

There has been strong pressure to modernize delivery and eliminate “silos,” which are seen as impeding smooth delivery and efficient use of resources. The US experience with managed care and the UK experience with general practitioner fundholders are frequently cited examples of what should or should not be achieved, depending on the political and managerial preferences of the observer. The push for integration has been expressed in many ways, including establishing regional health authorities and the ongoing attempt to achieve primary care reform. Physicians within the Canadian clinical workforce are unusual in the degree of autonomy they have enjoyed with respect to where they will work and in the volume and mix of services they choose to deliver.¹² Most other clinicians must be hired by a provider organization and are accordingly subject to labor market forces in determining whether (and where) employment is available. The question of whether this state of affairs should be continued or not is an ongoing source of dispute.

Allocation

Two opposing trends have been evident. Some provinces, for some sectors, have moved toward the planned end of the allocation continuum, usually accompanied by rhetoric about the need for integrated services, better planning, and more efficiency.¹⁹ For other sectors, there has been a movement toward more market-oriented approaches to allocation, usually linked to attempts to encourage competition. For example, Ontario assigned budgets for home care services to a series of re-

gionally based Community Care Access Centres, which in turn are expected to contract out publicly funded services on the basis of “best quality, best price.” The competing providers (both for-profit and not-for-profit) respond to each request for proposals; the expectation is that competition will lead to efficiencies (which usually translate into a downward pressure on the wages, skill mix, and working conditions of the nurses, rehabilitation workers, and homemakers employed by these agencies).^{26,27} Alberta wants to use competition and for-profit delivery to encourage similar efficiencies in the delivery of clinic services. Some academics suggest setting up competing integrated delivery models.²⁸

Considerable attention has been paid to benchmarking, quality assurance, “report cards,” and other mechanisms of improving accountability. Those seeking major reform tend to point with glee to any international evidence that Canada is no longer the best system. In that connection, the fact that the World Health Organization, using a controversial methodology that adjusted health system performance for the educational attainment of the population, ranked Canada 30th received considerably more attention than Canada’s preadjustment ranking of 7th in the same document.²⁹ Similarly, considerable attention was paid to Canada’s high level of health spending as a proportion of gross domestic product (GDP) (10.1% in 1992), but less to the fact that this reflected the relatively poorer performance of the economy, with actual spending in US dollars per capita being much lower.³⁰ (Indeed, as the economy did better, the ratio of spending to GDP dropped con-

siderably, reaching 9.2% by 2000.)

LESSONS FOR THE UNITED STATES

Size

A common fear about universal health insurance is that it requires a large and cumbersome bureaucracy. In that connection, it is important to recognize both that single-payer systems yield administrative efficiencies and that Canada’s model is organized at the provincial (state) level. Canada’s 2001 population was 30 million (vs 284.8 million in the United States); the largest provincial plan (Ontario’s) served 11.4 million. In contrast, the largest US insurance plan, Aetna, served 17.2 million health care members, 13.5 million dental members, and 11.5 million group insurance customers. A US model organized at the state (or even substate) level would allow for flexibility to account for local circumstances and would probably result in a less bureaucratic system than at present.

Another feature of size is the recognition that most Canadian communities are not large enough to support competition (particularly for specialized services), even should this be considered desirable.³¹ Small size also leads to problems in risk pooling, since one expensive case may place the entire plan at fiscal risk. Single-payer models encouraging cooperation are likely to be particularly applicable to the more rural portions of the United States.

Universal Coverage

A major advantage of a single-payer system is that one can attain universal coverage at a lower cost than is attained by

pluralistic funding approaches. Canada has universal coverage, excellent health outcomes, minimal paperwork, and high public satisfaction, although coverage or reimbursement decisions do tend to become political. One key advantage is the avoidance of risk selection; no one is uninsurable. In a pluralistic system, government often ends up with the worst risks, and the high costs associated with them. A single payer allows these costs to be spread more equitably. Canadian health policy largely accepts the limitations of markets in health care, at least for the portions deemed medically necessary.

It is striking that there are more people in the United States without health insurance than the entire population of Canada, with many more in the United States underinsured. Even in 1998, the United States was spending more per capita from public funds for health care than was Canada, in addition to the considerable spending from private sources.¹⁸ Hospitals, physicians, and patients are faced with considerably less administrative costs than in the United States, although this savings may also translate into considerably less administrative data. The one component in Canada that does use a US mix of public and private financing—outpatient pharmaceuticals—is the one part of the system where costs have been rising most quickly, and access is seen as most problematic.

Jurisdiction

Another lesson is that federalism imposes difficulties. Health policy has been damaged by the pitched battles between the national and provincial governments, which have also undermined public confidence in the

system. The balance between imposing national standards (and accountability for money spent) and respecting provincial jurisdiction and allowing flexibility is a tricky one, and it would be hard to argue that the present mix is optimal.

CONCLUSION

Despite the angst, the objective evidence suggests that the Canadian model has much to recommend it. Ironically, it is most threatened by proximity to the United States, and the concerted attacks from those favoring for-profit, market-oriented care on both sides of the border.^{32, 33} The success of earlier reforms may also have produced an excess of “efficiency” at the expense of health care workers and clients alike.³⁴ Nonetheless, the Romanow Commission has elicited a national, and heartfelt, public reaction. Canadians prize their system of universal coverage. Various changes at the margin are likely. The shape of the overall system, however, will probably remain relatively stable. The major lesson of the Canadian model is precisely the reluctance of Canadians to lose it. ■

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References

1. *Report and Recommendations: Emerging Solutions*. Québec, Québec: Commission d'étude sur les services de santé et les services sociaux (CESSSS); December 18, 2000. Available at: <http://www.cessss.gouv.qc.ca/pdf/en/01-109-01a.pdf>. Accessed October 11, 2002.
2. *Report of the Premier's Advisory Council on Health. A Framework for Reform*. Edmonton, Alberta: Premier's Advisory Council on Health for Alberta; December 2001. Available at: http://www.gov.ab.ca/home/health_first/documents_maz_report.cfm. Accessed October 11, 2002.
3. *Caring for Medicare: Sustaining a Quality System*. Regina, Saskatchewan: Saskatchewan Commission on Medicare; April 6, 2001. Available at: http://www.health.gov.sk.ca/info_center_pub_commission_on_medicare_bw.pdf. Accessed October 11, 2002.
4. *The Health of Canadians: The Federal Role*. 6 vol. Ottawa, Ontario: Standing Senate Committee on Social Affairs Science and Technology; 2001–2002. Available at: <http://www.parl.gc.ca/37/2/parlbus/commbus/sentate/com-e/soci-e/rep-e/repoct02vol6-e.htm>. Accessed November 22, 2002.
5. Commission on the Future of Health Care in Canada. Shape the future of health care: interim report. Available at: <http://www.healthcarecommission.ca.gov>. Accessed October 11, 2002.
6. Deber RB. Getting what we pay for: myths and realities about financing Canada's health care system. *Health Law Can*. 2000;21(2):9–56. Available at: <http://www.utoronto.ca/hpme/dhr/pdf/atrevise3.pdf>. Accessed November 22, 2002.
7. Forget EL, Deber RB, Roos LL. Medical savings accounts: will they reduce costs? *Can Med Assoc J*. 2002; 167:143–147.
8. *The Constitution Acts, 1867 to 1982*. Ottawa, Ontario: Government of Canada; 1982.
9. Taylor MG. *Health Insurance and Canadian Public Policy. The Seven Decisions That Created the Canadian Health Insurance System and Their Outcomes*. 2nd ed. Kingston, Ontario: McGill–Queen's University Press; 1987.
10. Maioni A. Parting at the crossroads: the development of health insurance in Canada and the United States. *Comp Polit*. 1997;29:411–432.
11. Naylor CD. *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance 1911–1966*. Kingston, Ontario: McGill–Queen's University Press; 1986.
12. Tuohy CH. *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*. New York, NY: Oxford University Press; 1999.
13. Government of Canada. *Hospital Insurance and Diagnostic Services Act*. Statutes of Canada, 5-6 Elizabeth II (c 28, S1 1957), 1957.
14. Government of Canada. *Medical Care Act*. Statutes of Canada (c 64, s 1), 1966–1967.
15. Government of Canada. *Canada Health Act, Bill C-3*. Statutes of Canada, 32-33 Elizabeth II (RSC 1985, c 6; RSC 1989, c C-6), 1984.
16. *Canada Royal Commission on Health Services*. Vol 1. Ottawa, Ontario: Canada Royal Commission on Health Services; 1964.
17. *Preliminary Provincial and Territorial Government Health Expenditure Estimates 1974/1975 to 2001/2002*. Ottawa, Ontario: Canadian Institute for Health Information; October 2001.
18. *OECD Health Data 2001: A Comparative Analysis of 30 OECD Countries* [CD-ROM]. Paris, France: Organization for Economic Cooperation and Development.
19. Church J, Barker P. Regionalization of health services in Canada: a critical perspective. *Int J Health Serv*. 1998;28: 467–486.
20. Lomas J, Woods J, Veenstra G. Devolving authority for health care in Canada's provinces, I: an introduction to the issues. *Can Med Assoc J*. 1997;156: 371–377.
21. Hutchison B, Abelson J, Lavis J. Primary care in Canada: so much innovation, so little change. *Health Aff (Millwood)*. 2001;20(3):116–131.
22. *Canadian Health Insurance: Lessons for the United States. Report to the Chairman, Committee on Government Operations, House of Representatives*. Washington, DC: US General Accounting Office; 1991.
23. Naylor CD. Health care in Canada: incrementalism under fiscal duress. *Health Aff (Millwood)*. 1999;18(3):9–26.
24. Armstrong P, Armstrong H, Coburn D, eds. *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada*. Don Mills, Ontario: Oxford University Press; 2001.
25. Williams AP, Deber RB, Baranek P, Gildiner A. From Medicare to home care: globalization, state retrenchment and the profittization of Canada's health care system. In: Armstrong P, Armstrong H, Coburn D, eds. *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada*. Don Mills, Ontario: Oxford University Press; 2001: 7–30.
26. Baranek P, Deber RB, Williams AP. Policy trade-offs in “home care”: the Ontario example. *Can Public Adm*. 1999;42(1):69–92.
27. Williams AP, Barnsley J, Leggat S, Deber RB, Baranek P. Long term care goes to market: managed competition and Ontario's reform of community-based services. *Can J Aging*. 1999; 18(2):125–151.
28. Leatt P, Pink GH. Towards a Canadian model of integrated healthcare. *HealthcarePapers*. 2000;1(2):13–36.
29. *The World Health Report 2000: Health Systems: Improving Performance*. Geneva, Switzerland: World Health Organization; 2000.
30. Deber RB, Swan B. Canadian health expenditures: where do we really stand internationally? *Can Med Assoc J*. 1999;160:1730–1734.
31. Griffin P, Cockerill R, Deber RB. Potential impact of population-based funding on delivery of pediatric services. *Ann R Coll Physicians Surg Can*. 2001;34:272–279.
32. Evans RG. Going for the gold: the redistributive agenda behind market-based health care reform. *J Health Polit Policy Law*. 1997;22:427–466.
33. Evans RG, Roos NP. What is right about the Canadian health care system? *Millbank Q*. 1999;77:393–399.
34. Stein JG. *The Cult of Efficiency*. Toronto, Ontario: House of Anansi Press Ltd; 2001.